John Joseph Moakley
Courthouse
1 Courthouse Way
Boston, Ma.
Ward 1A

RBC
05mj00428

FILED
CLERKS OFFICE
2005 AUG 29 P 3:15
U.S. DISTRICT COURT
DISTRICT OF MASS

8/25/05

To whom it may concern,

I am personally sending you a copy of the DMH application for Adult Continuing care and services that was requested from the courts through the attorney that was officially fired twice by me (Mr. Robert Murray).

This application was honored by me with the understanding that I was or am to agree to DMH services upon leaving on my court date or be re-evaluated which would possibly take up to an additional 2 months.

Even though I fired mr. Murray once again on Tues. 8/23/05 verbally by telephone

Commonwealth of Massachusetts
Department of Mental Health

APPLICATION FOR ADULT CONTINUING CARE SERVICES **(June 20, 2003)**

INSTRUCTIONS:
This form is for applicants **19 years of age or older**.

The applicant, his or her legal guardian, or someone assisting the applicant, should complete →**SECTION 1**.

A treating clinician or other person with knowledge of the applicant's history should complete →**SECTION 2** of the application and the →**CLINICAL ASSESSMENT OF RISK, BEHAVIOR AND REHABILITATION NEEDS OF ADULTS**.

These sections and the signed →**AUTHORIZATION FOR DMH ELIGIBILITY DETERMINATION** must be returned to the Department of Mental Health Eligibility Unit serving the applicant's area of the state.

DMH Eligibility Units:

Western Massachusetts Area Eligibility Determination Unit
P.O. Box 389, Northampton, MA 01061-0389
Phone: (413) 587-6200 Fax: (413) 587-6205

Central Massachusetts Area Eligibility Determination Unit
305 Belmont Street, Worcester, MA 01604
Phone: (508) 368-3838 Fax: (508) 363-1500

Metro Suburban Area Eligibility Determination Unit
P.O. Box 288 – Lyman Street, Westboro, MA 01581
Phone: (508) 616-2186 Fax (508) 616-3599

North East Area Eligibility Determination Unit
P.O. Box 387, Tewksbury, MA 01876-0387
Phone: (978) 863-5000 Fax (978) 863-5091

Metro Boston Area Eligibility Determination Unit
85 East Newton Street, Boston, MA 02118
Phone: (617) 626-9217 Fax: (617) 626-9216

Southeastern Area Eligibility Determination Unit
165 Quincy Street, Brockton, MA 02302
Phone: (508) 897-2000 Fax (508) 897-2024

DMH Information and Referral service: 1-800-221-0053 (regular business hours only)

DMH web site: www.state.ma.us/dmh

Commonwealth of Massachusetts
Department of Mental Health

APPLICATION FOR ADULT CONTINUING CARE SERVICES (Jun 20, 2003)

SECTION 1: PERSONAL INFORMATION – completed by the applicant, his or her legal guardian, or someone assisting the applicant

1. Name Adams (Last) Shirron (First) M. (Mi) 2. SSN 011-56-7655 (Social Security Number)

3. Address 16 Slayton Way (Number and Street) (Apt No) Roxbury (City) MA (State) 02119 (Zip Code)

4. Telephone (617) 445-5602 (day) ( ) (evening) message

5. Birth Date 05/17/74 (MM / DD / YY) 6. Age 31 (In Years) 7. Gender F (M / F) 8. Race/Ethnicity African-American

9. Does applicant speak English? ☑ Yes ☐ No ☐ Limited 10. Preferred Language/Dialect English

11. Literate in English? ☑ Yes ☐ No ☐ Limited
11a. Literacy in the applicant's native language? ☑ Yes ☐ No ☐ Limited

12. Citizenship US 13. Country of origin US 14. Length of stay in U.S. 31 yrs

15. Religion Christian

16. Does applicant have a court appointed legal guardian? ☐ Yes ☑ No

17. Name of legal guardian (Last) (First) Relationship (to Applicant)

18. Telephone ( ) (day) ( ) (evening)

19. Emergency contact person (Last) (First) 20. Telephone ( )

21. **HEALTH INSURANCE** a) ☑ No health insurance b) ☐ No mental health benefit

c) ☐ Application for Health Insurance Pending

d) ☐ Medicare e) ☐ Medicare/Medicaid

f) ☐ Medicaid/MassHealth Card #: g) RID #:

MassHealth Provider
h) ☐ HMO (Name of HMO) i) ☐ Primary Care Clinician Program (PCC) j) ☐ Other

k) ☐ Private insurance l) Name of Insurance: m) Policy #:

n) Name of Policy Holder:

22. **SOURCE OF INCOME**

a) ☐ Employment b) ☐ SSDI c) ☐ SSI d) ☐ EAEDC e) ☐ Social Security f) ☐ Family

g) ☒ Other sources If other, explain: Frozen by Federal Court. h) Estimated Personal Monthly Income: Ø

Applicant Name:

Applicant Name:

AUTHORIZATION FOR DMH ELIGIBILITY DETERMINATION

- I request that the Department of Mental Health (DMH) conduct a determination of eligibility for continuing care services. I have attached signed release of information forms to this application if necessary. I understand that DMH will collect and review medical records as part of the determination of eligibility. I understand that my name and information about me will be included in a DMH record keeping system.
- DMH may, at its discretion, request a personal interview with me or a clinical evaluation in circumstances where the available clinical records are not sufficient to make a determination of eligibility.
- In addition, I will be required to disclose information about my income and insurance and may be charged for services according to my ability to pay.
- I also understand that I may appeal the decision of DMH in determining whether or not I am eligible for DMH continuing care services.
- I received a copy of the DMH Notice of Privacy Practices (appended to this application)

X _____ Shirron Adams 8/25/05

Signature of applicant or legal guardian of the person | Applicant Name (Print) | Date signed

PERSON ASSISTING APPLICANT

This section to be completed by provider or other person assisting applicant with the application.

Name Rivera-Vega (last) Adalberto (first) Relationship Social Worker (relationship to applicant)

Address 305 Belmont St. (number and street) 1A (apt no) Worcester (city) MA (state) 01604 (zip code)

Telephone (508) 368 3486 (day time) ( ) _____ (evening)

PROGRAM OR FACILITY SUBMITTING APPLICATION ON BEHALF OF APPLICANT

This section to be completed by program or facility submitting application on behalf of applicant

_____ Name of Program or Facility

_____ Name of Applicant

☐ The applicant was informed on _____ that an application was being filed on his/her behalf and he/she did not object

☐ The applicant is incapable and a petition for guardianship was filed in the appropriate court (copy of petition is attached)

_____ Your Name (please print)

_____ Your Signature and Title

TO SUBMIT RELEASE OF MEDICAL INFORMATION FORMS

As part of the determination of eligibility, the Department of Mental Health will review records of all mental health care provided to the applicant during the past 24 months.

1. Please submit one signed *Authorization for Release of Information* form for each provider of mental health care during the past 24 months. If mental health care was provided through a clinic, please identify a primary provider of care at that clinic.
2. In addition, please submit an *Authorization for Release of Information* form for any other clinical information the applicant would like to have considered as part of the determination of eligibility.
3. Please double check the accuracy of the provider's name, address, and phone number on each release form. Please make a phone call if necessary to verify information on the *Authorization for Release of Information* form. Correct names and addresses expedite the eligibility review process.
4. Please submit signed *Authorization for Release of Information* forms along with the application, if possible.

How many *Authorization for Release of Information* forms are being submitted with this application? 6

The Department will also review any medical records that the applicant or those assisting the applicant may have in their possession and wish to submit for consideration.

1. Please complete and sign an *Authorization for Release of Information* form for each medical record that is attached to this application in case DMH staff need to clarify information contained in the report.
2. Copies of medical reports cannot be returned so please do not send original copies.

How many copies of medical reports are attached to this application? ☐